

SPECIAL NEEDS/CHILD PLACEMENT QUESTIONNAIRE

Welcome to Fort Irwin Child and Youth Services programs. If your child should have a special need prior knowledge will allow us to make appropriate adjustments to our program and provide training to the staff.

Child's Name: _____ Date of Birth: _____

Program/Bkg: _____ Today's Date: _____

Does your child/youth have any of the following conditions?

	YES	NO		YES	NO
Developmental delays Explain: _____			Asthma/Respiratory		
Visual Problems/Blindness (Do not check this box if your child only wears glasses)			Speech/Language Delays		
Hearing Problems (Check this box if our child has had Tubes) Explain: _____			Allergic Reactions Explain: _____		
Physical Disability Explain: _____			Behavioral/Conduct Concerns		
Sickle-Cell Disease (Do not check this box if your child has only the Sickle Cell trait)			Heart Problems		
Kidney Problems Explain: _____			Diabetes		
Epilepsy/Seizures			Attention Deficit /Hyperactivity (ADD/ADHD)		
Autism			Other (Please specify)		

2. Is your child taking medication for his/her condition if so please specify.

3. Is your child receiving services from Behavioral Medicine? If yes please explain. Yes No

4. Is your child enrolled in a Developmental Preschool Yes No

5. Is your child enrolled in the Exceptional Family Member Program Yes No

Signature of Parent/Guardian _____

Home and Duty Phone _____

Print Name (state rank if applicable) _____

(OFFICE USE ONLY)

History of Special Need/Medical Condition:

Recommendation: a. Admit/No Significant Modification needed _____ b. Admit w/Care Plan Training date _____ c. Schedule SNRT Date/Time _____

Name of CYS Child and Youth Services program official: _____